2018 ASAGA Conference

Sex, Drugs and Rock & Roll

Atypical Beneficiary Requests

APPENDIX

Megan Brand, Executive Director
Colorado Fund for People with Disabilities (CFPD)

Marco Chayet, Esq.
Chayet & Danzo, LLC

Peter Wall, Vice President
Colorado State Bank and Trust

Sex, Drugs, and Rock & Roll
Appendix, Section 1

Sample Settlor Letter of Intent

Date: _____

Dear Trustee and [Son, Daughter, Etc.],

I feel incredibly blessed to have been able to provide for my family's ongoing support after my death through the funding of this XYZ TRUST. It is my desire that this trust will continue to aid in my family's growth and development as the productive, thoughtful and caring citizens that they already are. The legalese contained within the XYZ TRUST is meant to guide my trustee and provide a legally sound structure for them to do so in a prudent, tax-advantaged manner. However, the purpose behind this letter is to give greater insight to both BENEFICIARY and TRUSTEE as to my desires and wishes regarding the administration of the TRUST.

In the course of any trust's administration, the trustee must act prudently and must typically strive to preserve the trust's corpus for the lifetime of the beneficiary. Please know that this is not my intent in establishing the XYZ TRUST. My intent of this trust is to provide BENEFICIARY with the financial means and support to pursue his/her dreams and opportunities to their fullest in accordance with the prudence and discretion any prudent person would use. I do not care if BENEFICIARY is a poet, a musician, an investment banker or a stock broker. I only care that BENEFICIARY is happy, provided for and engaged in the decision making process of TRUSTEE. In other words, the preservation of principal of the XYZ TRUST is not as important to me so long as BENEFICIARY is thriving.

It is possible that any beneficiary (current or remainderperson) may become disabled at some point, thus necessitating their application for public benefits. Again, as noted above, it is my desire that any of my beneficiaries enjoy a good quality of life and are comfortable, even at the expense of the longevity of the trust. In accordance with these desires, I request that TRUSTEE consult with XYZ TRUST ADVISOR should any distribution from TRUST be denied solely to prolong the principal of TRUST.

I understand that these requests of mine herein are precatory and not legally binding on TRUSTEE or BENEFICIARY, but ask that they be honored nonetheless.

Lovingly,

_____

SETTLOR

Sex, Drugs, and Rock & Roll
Appendix, Section 2

Sample Beneficiary Profile Form

[The balance of this page is left intentionally blank.]

Sample Beneficiary Intake Form

Instructions: *Please fill out every line.* ***If the information does not apply, please indicate "n/a"***

Name of person completing forms _____

Relationship to Client _____

Main Telephone _____ Alternate _____ Fax _____

Email _____

Client Information

Name of Client _____

Social Security # _____

Date of Birth _____ City & State of Birth _____

Photo ID or Driver's License # _____ State _____ Expiration Date _____

Mailing Address

Address Line One _____

Address Line Two _____

City _____ State _____ Zip _____

Physical Address

Address Line One _____

Address Line Two _____

City _____ State _____ Zip _____

What county does the Client live in? _____

Main Telephone _____ Alternate _____ Fax _____

Email _____

Client lives

☐ Independently at home/apartment ☐ Nursing home ☐ Assisted living

☐ Independent living center ☐ Rehab hospital ☐ Regional center

☐ Group home ☐ Host home

☐ With family (specify relationship)

☐ Other (specify)

Mother's Name _____

Father's Name _____

Spouse _____

Client's Minor Children Name/Date of Birth

_____

_____

Referral Information

☐ Ad ☐ Associate ☐ Mailer ☐ Referral ☐ Trade Show ☐Attorney ☐ Other

Referrer's Name _____

Relationship to Client _____

Main Telephone _____ Alternate _____ Fax _____

Email _____

Address Line One _____

Address Line Two _____

City _____ State _____ Zip _____

Disability (*Proof of Disability must accompany this form)*

What is the **PRIMARY** nature of the Client's disability?

Date of onset _____

Check ONE

☐ Brain/Head Injury

☐ Cerebral Palsy

☐ Autism

☐ Intellectual/Cognitive Disability

☐ Mental Illness

☐ Substance Abuse/Addiction

☐ Multiple Sclerosis

☐ Spinal Cord Injury

☐ Physical Disability

☐ Dementia/Alzheimer's Disease

☐ Other – please describe

What is the SECONDARY nature of the Client's disability?

Please check all that apply

☐ Brain/Head Injury

☐ Cerebral Palsy

☐ Autism

☐ Intellectual/Cognitive Disability

☐ Mental Illness

☐ Substance Abuse/Addiction

☐ Multiple Sclerosis

☐ Spinal Cord Injury

☐ Physical Disability

☐ Dementia/Alzheimer's Disease

☐ Other – please describe

Background Information *(CFPD reserves the right to do a full background check.)*

Is there any history or behavior related to the Client that the staff should be aware of? ☐Yes ☐ No

If yes, explain

Has the Client ever been convicted of a felony? ☐Yes ☐ No

If yes, explain

Does the Client have any judgments or liens? ☐Yes ☐ No

If yes, explain

Does the Client owe any restitution? ☐Yes ☐ No

If yes, explain

Does the Client have any outstanding attorney fees? ☐Yes ☐ No

If yes, explain

Have you or the Client consulted with an attorney? ☐Yes ☐ No

If yes, explain

Does the Client currently own real estate? (If yes, provide address and how titled) ☐Yes ☐ No

If yes, explain

Does the Client currently have any foreign financial accounts? (If yes, provide statement) ☐Yes ☐ No

If yes, explain

Benefits/Income

MUST disclose ALL assets and income and any changes including WORK income & inheritances.

Please attach copies of all government assistance and income that the Client receives

☐ Supplemental Security Income (SSI)	$	per month
☐ Social Security Disability Insurance (SSDI)	$	per month
☐ Social Security (SSA)	$	per month
☐ Other Social Security	$	per month
☐ Old Age Pension (OAP)	$	per month
☐ Food Stamps	$	per month
☐ Worker's Compensation	$	per month
☐ Annuity Payment	$	per month
☐ Work Income	$	per month
☐ Spousal Maintenance	$	per month
☐ Child Support	$	per month
☐ Other	$	per month

Medicaid # _____

Is the Medicaid application pending? ☐ Yes ☐ No

Does Client plan to apply for Medicaid? ☐ Yes ☐ No

Medicare # _____

Is the Client in the waiting period? ☐ Yes ☐No

☐ Social Security (SSI)

☐ Medicare Savings Programs (Qualified Medicare Client)

- ☐ QMB
- ☐ SLMB
- ☐ QL1
- ☐ ODWI

☐ Home & Community Based Services

- ☐ Children's HCBS
- ☐ HCBS Children with Autism Waiver HCBS-CWA
- ☐ Children's Extensive Support Waiver HCBS-CES
- ☐ Children's Habilitation Residential Program Waiver HCBS-CHRP

☐ HCBS Waiver for Persons with Brain Injury HCBS-BI

☐ HCBS Waiver for Persons with Mental Illness HCBS-MI

☐ HCBS Waiver for Persons living with AIDS HCBS-PLWA

☐ HCBS Waiver for Persons who are Elderly, Blind and Disabled HCBS-EBD

☐ Pediatric Hospice Waiver HCBS-PHW

☐ Supported Living Services Waiver HCBS-SLS

☐ Waiver for Persons Developmentally Disabled HCBS-DD

☐ PACE Program of all inclusive care for the elderly

☐ Long Term Care

☐ Nursing Home ☐ Assisted Living ☐ Home

Health Insurance

Insurer _____

Address _____

City, St. Zip _____

Policy # _____

Name of Primary Policy Holder _____

Secondary Health Insurance information _____

Funding

Anticipated amount of initial funding $ _____

Anticipated funding date _____

Source ☐ Annuity ☐ Personal Injury Settlement ☐ Inheritance ☐ Divorce Settlement ☐ Sale of Home

☐ Liquidation of Personal Assets ☐ Social Security Back-Payment ☐ Other: _____

Anticipated additional/ongoing deposits to trust $ _____

Source of additional deposits _____

Disclaimer

_____ **(Initials) Based on Federal and State law, the purpose of a Supplemental Needs Trust is to provide a way for a Client to receive a personal injury settlement, back payment from Social Security, inheritance, etc., without jeopardizing their eligibility for government benefit programs. My initials indicate that I recognize that XYZ Trust Company cannot guarantee continuing eligibility for government benefits. I also recognize that there is a time frame for filing an appeal which may be as short as 10 days. It is my responsibility to notify XYZ Trust Company immediately upon receiving a notice of denial of benefit, and to request any assistance I may need.**

Section 8 Disclaimer

XYZ Trust Company needs to determine if you receive Section 8 or reside in Public Housing. These programs recognize your Trust as a protected asset, but may count "regular" disbursements or payments made on your behalf, such as phone, cable and gym memberships as income to you. **If you receive Section 8/Public Housing, disbursements from your trust could ultimately increase the amount of rent you pay.** We must carefully evaluate all "regular" disbursements or payments made on your behalf in order to protect your Section 8/Public Housing benefit.

Please mark yes or no for the following questions:

☐ Yes ☐ No Do you or your family receive Section 8?

☐ Yes ☐ No If you live in an Assisted Living Facility, do you receive a Section 8 voucher to pay your rent?

☐ Yes ☐ No Do you or your family live in Public Housing?

☐ Yes ☐ No Is your rent or your family's rent based on your income?

If you answered **yes** to any of the questions above, please fill out the following for your Section 8 contact. Section 8/Public Housing will be discussed with you at your Assessment and Plan meeting.

Landlord or Agency:

Name					
Company Name					
Address					
City		State		Zip	
Main Telephone		Alternate		Fax	
E-mail Address					

_____ **(Initials)** I recognize that XYZ Trust Company cannot guarantee continuing eligibility for Section 8/Public Housing Benefits. I understand that it is my responsibility to respond in a timely manner to my Section 8/Public Housing redetermination and to report any changes in rent or denial of benefits to XYZ Trust Company.

End of Life Plans

_____ **(Initials)** We encourage each of our Beneficiaries to consider the purchase of a cremation or burial plan with the money they place in our Trust. **The Social Security Act prohibits a Supplemental Needs Trust from paying for these expenses after the death of the Client.** XYZ Trust Company must follow this regulation. Please tell us what you prefer to do:

☐ I want to discuss the purchase of a cremation or burial plan

☐ I already have a cremation or burial plan (please attach a copy of the policy)

Insurer _____

Policy # _____

Address _____

☐ I decline the purchase of a cremation or burial plan

Representatives / Contacts *(Notify us in writing of any change)*

Medicaid County Eligibility Technician

County _____

Contact Name _____

Main Telephone _____ Alternate _____ Fax _____

E-mail Address _____

Rep - Payee

Name _____ Relationship: _____

Company Name _____

Address _____

City _____ State _____ Zip _____

Main Telephone _____ Alternate _____ Fax _____

E-mail Address _____

☐Yes ☐ No XYZ Trust Company may consult with this person(s) regarding distributions

☐Yes ☐ No XYZ Trust Company may send correspondence to this person regarding the account

☐Yes ☐ No XYZ Trust Company should include this person in Assessment and Planning meetings

Special Instructions

Guardian *(please attach Court Guardianship Letters)*

Name			Relationship:		
Company Name					
Address					
City		State		Zip	
Main Telephone		Alternate		Fax	
E-mail Address					

XYZ Trust Company will consult with this person(s) regarding distributions

XYZ Trust Company will send correspondence to this person regarding the account

XYZ Trust Company will include this person in Assessment and Planning meetings

Special Instructions

Co-Guardian *(please attach Court Guardianship Letters)*

Name			Relationship:		
Company Name					
Address					
City		State		Zip	
Main Telephone		Alternate		Fax	
E-mail Address					

XYZ Trust Company will consult with this person(s) regarding distributions

XYZ Trust Company will send correspondence to this person regarding the account

XYZ Trust Company will include this person in Assessment and Planning meetings

Special Instructions

Conservator *(please attach Court Conservatorship Letters)*

Name			Relationship:		
Company Name					
Address					
City		State		Zip	
Main Telephone		Alternate		Fax	
E-mail Address					

XYZ Trust Company will consult with this person(s) regarding distributions

XYZ Trust Company will send correspondence to this person regarding the account

XYZ Trust Company will include this person in Assessment and Planning meetings

Special Instructions

Power of Attorney (POA) *(please attach)* ☐ *Financial* ☐ *Medical* ☐ *Durable/General*

Name			Relationship:		
Company Name					
Address					
City		State		Zip	
Main Telephone		Alternate		Fax	
E-mail Address					

☐Yes ☐ No XYZ Trust Company may consult with this person(s) regarding distributions

☐Yes ☐ No XYZ Trust Company may send correspondence to this person regarding the account

☐Yes ☐ No XYZ Trust Company should include this person in Assessment and Planning meetings

Special Instructions

Attorney ☐ PI ☐ Elder Law ☐ Estate Planning

Name _____ Relationship: _____

Company Name _____

Address _____

City _____ State _____ Zip _____

Main Telephone _____ Alternate _____ Fax _____

E-mail Address _____

☐Yes ☐ No XYZ Trust Company may consult with this person(s) regarding distributions

☐Yes ☐ No XYZ Trust Company may send correspondence to this person regarding the account

☐Yes ☐ No XYZ Trust Company should include this person in Assessment and Planning meetings

Special Instructions

Attorney ☐ PI ☐ Elder Law ☐ Estate Planning

Name _____ Relationship: _____

Company Name _____

Address _____

City _____ State _____ Zip _____

Main Telephone _____ Alternate _____ Fax _____

E-mail Address _____

☐Yes ☐ No XYZ Trust Company may consult with this person(s) regarding distributions

☐Yes ☐ No XYZ Trust Company may send correspondence to this person regarding the account

☐Yes ☐ No XYZ Trust Company should include this person in Assessment and Planning meetings

Special Instructions

☐ **Host Home** ☐ **Group Home** ☐ **Assisted Living** ☐ **Nursing Home Provider** ☐ **Home**

Name			Relationship:		
Company Name					
Address					
City		State		Zip	
Main Telephone		Alternate		Fax	
E-mail Address					

☐Yes ☐ No XYZ Trust Company may consult with this person(s) regarding distributions

☐Yes ☐ No XYZ Trust Company may send correspondence to this person regarding the account

☐Yes ☐ No XYZ Trust Company should include this person in Assessment and Planning meetings

Special Instructions

In case of Emergency

Name			Relationship:		
Company Name					
Address					
City		State		Zip	
Main Telephone		Alternate		Fax	
E-mail Address					

☐Yes ☐ No XYZ Trust Company may consult with this person(s) regarding distributions

☐Yes ☐ No XYZ Trust Company may send correspondence to this person regarding the account

☐Yes ☐ No XYZ Trust Company should include this person in Assessment and Planning meetings

Special Instructions

Other People in your life *(include spouse or significant other) Attach separate sheet if there are additional people you would like us to know about.*

Name			Relationship:		
Company Name					
Address					
City		State		Zip	
Main Telephone		Alternate		Fax	
E-mail Address					

☐Yes ☐ No XYZ Trust Company may consult with this person(s) regarding distributions

☐Yes ☐ No XYZ Trust Company may send correspondence to this person regarding the account

☐Yes ☐ No XYZ Trust Company should include this person in Assessment and Planning meetings

Special Instructions

Immediate Needs

Does the Client plan to request the purchase of a home? ☐Yes ☐ No

If yes, explain

Does the Client plan to request the purchase of a vehicle? ☐Yes ☐ No

If yes, explain

Does the Client plan to request monthly budgetary needs? ☐Yes ☐ No

If yes, explain

Does the Client plan to request any one time upfront special distributions (i.e. vacations, trips, etc)?

☐Yes ☐ No

If yes, explain

Does the Client plan to request any one time or monthly medical distributions (i.e. alternative therapies, procedures not covered by benefits, etc)?

☐Yes ☐ No

If yes, explain

Is there anything else you'd like us to know? ☐Yes ☐ No

If yes, explain

Do you have any questions we can address? ☐Yes ☐ No

If yes, explain

Optimal Outcomes

Where does the Client see themselves in 1 year?

Where does the Client see themselves in 5 years?

Where does the Client see themselves in 10 years?

Does the Client anticipate future educational needs?

Does the Client have vocational ambitions?

What motivates the Client (ambitions, dreams, artistic, etc)?

Does the client have a favorite sports team, hobby or passion?

Does the client have a need for Estate Planning? If so, how soon? (Note: obtain estate planning documents as applicable).

Initial Investment Profile

Which of the following best describes the Client's investment objective?

1) Preservation of Principal/Moderate Income
2) High Income
3) Some income/growth
4) High Growth

How much of the Client's assets does the trust represent?

1) 75-100%
2) 50-74%
3) 25-49%
4) 1-24%

What kind of growth is the Client expecting in the portfolio's value in the next 10 years?

1) A small amount
2) A moderate amount
3) A great deal

What is the client's income requirement from the portfolio?

1) High
2) Moderate
3) Low

How far in advance can the Client determine when they will need income?

1) Can't – may need it very quickly
2) Very little advanced notice
3) Some advance notice
4) Advance notice every time

What is the time frame for the Client's account to achieve its goals?

1) 0-5 years
2) 5-10 years
3) 10-15 years
4) Over 15 years

If the Client received a substantial amount of funds, how would they invest it?

1) Very safe with moderate income
2) Moderate risk with high income
3) Moderate/high risk with total return (income + appreciation)
4) High risk with high capital appreciation

How would the Client react to sudden declines in portfolio value?

1) Very concerned/unacceptable
2) OK if income was unaffected
3) Long term growth is anticipated, but temporary declines are bad
4) Long term growth is anticipated, but temporary declines are OK

Documents Checklist

☐ Most Recent Payroll Stub:

Comments:_____

☐ Personal Income Tax Returns For The Following Years:_____

Comments:_____

☐ Fiduciary Income Tax Returns For The Past Three Years:

Comments:_____

☐ Personal Employment Benefit Statements:

Comments:_____

☐ Company Benefit Plan Booklets (Group Benefits & Pension Plans):

Comments:_____

☐ SSA and Medicaid/Medicare Forms/Determinations:

Comments:_____

☐ Wills:

Comments:_____

☐ Trust Arrangements:

Comments:_____

☐ Business Arrangements:

Buy-Sell:_____

Deferred Compensation:_____

Stock Option/Bonus Plan:_____

☐ Insurance & Annuity Contracts:

Life Insurance:_____

Health Insurance:_____

Hospital & Major Medical:_____

Disability Insurance:_____

Property & Casualty:_____

Long-Term Care Insurance:_____

☐ Driver's License/Passport/ID Card:

Comments:_____

☐ W-9:

Comments:_____

X_____ **Date** _____

Relationship to Client ☐ Client ☐ Parent(s) ☐ Grandparent ☐ Guardian ☐ Conservator

Verification of Satisfaction of Medicare and Medicaid Liens

Personal Injury Settlements ONLY

Your trust will not be funded if this form is not complete.

Please provide documentation of satisfaction of liens.

☐ I was not represented by counsel in my personal injury case that is now funding my trust with XYZ Trust Company. By signing this document, I am verifying that all Medicare (if applicable) liens have been satisfied with the appropriate agency.

☐ I was not represented by counsel in my personal injury case that is now funding my trust with XYZ Trust Company. By signing this document, I am verifying that all Medicaid (if applicable) liens have been satisfied with the appropriate agency.

Comments: _____

_____ _____

Signature Date

I represented _____
in his/her personal injury case that is now funding his/her Trust with XYZ TRUST

☐By signing this document, I am verifying that all Medicare (if applicable) liens have been satisfied with the appropriate agency.

☐By signing this document, I am verifying that all Medicaid (if applicable) liens have been satisfied with the appropriate agency.

Comments: _____

Copies of lien payments should be submitted with this form.

_____ _____

Signature of Attorney Date

Attorney					
Company Name					
Address					
City		State		Zip	
Main Telephone		Alternate		Fax	
E-mail Address					

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor, you may complete this form to release only the minor's non-medical records. If you are requesting information for a purpose not directly related to the administration of any program under the Social Security Act, a fee may be charged.

NOTE: Do not use this form to:

- Request us to release the medical records of a minor. Instead, contact your local office by calling 1-800-772-1213 (TTY-1-800-325-0778), or
- Request information about your earnings or employment history. Instead, complete form SSA-7050-F4 at any Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the information applies.
- Fill in the name and address of the individual (or organization) to whom you want us to release your information.
- Indicate the reason you are requesting us to disclose the information.
- Check the box(es) next to the type(s) of information you want us to release including the date ranges, if applicable.
- You, the parent or legal guardian acting on behalf of a minor, or the legal guardian of a legally incompetent adult, must sign and date this form and provide a daytime phone number where you can be reached.
- If you are not the person whose information is requested, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. The information you provide will be used to respond to your request for SSA records information or process your request when we release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent.

We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided on this form in accordance with approved routine uses, which include but are not limited to the following: 1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and/or coverage; 2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; 3. To comply with Federal laws requiring the disclosure of the information from our records; and, 4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and other Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TTY 1-800-325-0778).** ***You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

*SSA will not honor this form unless all required fields have been completed (*signifies required field).*

TO: Social Security Administration

*Name _____ *Date of Birth _____ *Social Security Number _____

I authorize the Social Security Administration to release information or records about me to:

*NAME	*ADDRESS
CFPD - Colorado Fund for People with Disabilities	1355 S. Colorado Blvd. Suite 120, Denver, CO 80222

*I want this information released because:
There may be a charge for releasing information.
I need assistance to explain how the trust relates to my social security benefits

*Please release the following information selected from the list below:
You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- ☐ Social Security Number
- ☐ Current monthly Social Security benefit amount
- ☐ Current monthly Supplemental Security Income payment amount
- ☐ My benefit/payment amounts from _____ to _____
- ☐ My Medicare entitlement from _____ to _____
- ☐ Medical records from my claims folder(s) from _____ to _____
  If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.
- ☐ Complete medical records from my claims folder(s)
- ☒ Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.) Information related to my eligibility for SSA benefits

I am the individual to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

*Signature: _____ *Date: _____

Relationship *(if not the individual)*: _____ *Daytime Phone: _____

Sex, Drugs, and Rock & Roll
Appendix, Section 3

Sample Beneficiary Distribution Form

[The balance of this page is left intentionally blank.]

Discretionary Distribution Request Form

Account #:
Account Name:
Administrator:
Date:

Capacity:	Executor/PR	Guardian/Conservator of Estate	Trustee – Sole
	Other	Guardian/Conservator of Person	Co-Trustee

Distribution request: (do not aggregate dollar amounts)

Who Is Requesting Distribution:
Relationship to Beneficiary:

Current Total Request: Total requests for past 12 months:
Current Market Value: Estimated Annual Income:

Instrument:	Simple Trust	Complex Trust	Agency
Funding Mechanism:	1st Party	3rd Party	
Pooled (Y/N):			

Is distribution subject to GST Tax? (Y/N)

Pertinent Trust Provisions (please quote trust document verbatim):

Beneficiary(ies) with Date of Birth:

Remainderperson(s):

Public Benefits Synopsis:

Effect to Public Benefits of proposed distribution:

Beneficiary Personal Data:

Recommendation:

Sex, Drugs, and Rock & Roll
Appendix, Section 4

Sample Trust Protector/Trust Advisor Language

Designation of Trust Protector/Advisor

XYZ is appointed as the Trust Protector/Advisor and is granted the power to remove any Trustee, with or without cause. Upon removal of a Trustee, the Trust Protector/Advisor may appoint a corporate or professional fiduciary to serve as Trustee in the manner set forth in XYZ.

Function of the Trust Protector/Advisor

The function of a Trust Protector/Advisor is to assist, if needed, in protecting the interests and well-being of the beneficiary and in achieving the objectives of this trust. A Trust Protector/Advisor may not appoint itself as a Trustee and may not simultaneously serve in dual capacities. The Trust Protector/Advisor shall have access to all statements of trust activity, all information regarding the trust and shall have the right to full communication with the Trustee as related to the implementation and administration of the Trust. Any and all rights accorded a Trust Protector/Advisor under the terms of this agreement shall be exercised in a non-fiduciary capacity.

Resignation of Trust Protector/Advisor

Any Trust Protector/Advisor may resign by giving thirty days' written notice to the Trustee and to the current qualified beneficiary of the trust. Such resignation shall be made in writing.

Appointment of a Successor Trust Protector/Advisor

Upon the resignation of any of the aforementioned designated Trust Protector/Advisor, the resigning Trust Protector/Advisor may appoint their successor concurrent with such written resignation notice. In no case shall the Trust Protector/Advisor be compelled to appoint a successor Trust Protector/Advisor in the event that they determine a Trust Protector/Advisor is no longer needed.

Rights of Successor Trust Protector/Advisor

Any successor Trust Protector/Advisor shall have all of the authority of any predecessor Trust Protector/Advisor, but shall not be responsible for the acts or omissions of its predecessor.

Good Faith Standard Imposed

The authority of a Trust Protector/Advisor is conferred in non-fiduciary capacity only, and Trust Protector/Advisor shall not be liable for any action taken in good faith. A Trust Protector/Advisor shall not be liable for any act or omission on behalf of the Trustee.

Not a General Power of Appointment

A Trust Protector/Advisor may not participate in the exercise of a power or a discretion conferred under this instrument that would cause Trust Protector/Advisor to possess a general power of appointment within the meaning of Internal Revenue Code Sections 2041 and 2514.

Compensation

Any Trust Protector/Advisor serving under this instrument is entitled to receive reasonable compensation for services as determined by the Trustee. The Trust Protector/Advisor is entitled to reimbursement for all expenses incurred in the performance of its duties as trust advisor, including travel expenses.